Fax Number
(801) 288-5342
PLEASE USE BLACK INK

FUNCTIONAL ABILITY EVALUATION MEDICAL REPORT

TOP PORTION MUST BE COMPLETED BY APPLICANT

UTAH DRIVER LICENSE DIVISION
P O BOX 30560
SLC UT 84130-0560
(801) 965-4437 www.driverlicense.utah.gov

Last Name **First Name** **Middle or Maiden Name** **Date of Birth** **Driver License Number**

Street Address **City** **State** **Zip Code** **Social Security Number / ITIN**

☐ Address above is different from the address showing on my Driver's License.

As part of my application for driving privileges, the following information about my physical, mental and emotional health is submitted. Report below anything which might affect driving, such as seizures, heart attacks, use of alcohol or other drugs, psychiatric conditions, accidents, visual loss, etc. Give date(s) of last occurrence(s) and any medications being used: _____

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P. O. Box 30560, Salt Lake City, Utah 84130-0560. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand that I may refuse to sign this Authorization. If I fail to sign this Authorization my driving privilege may be affected. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it. I understand that I may request a copy of this signed Authorization.

Date: _____ **APPLICANT'S SIGNATURE:**_____

Commercial Intrastate drivers (Class A, B, C, D Licenses) must be profiled in ALL categories by the examining health care professional.

HEALTH CARE PROFESSIONAL REPORT BELOW

The following functional ability profile is for use in determining driving privileges. It is consistent with **Functional Ability in Driving: Guidelines and Standards for Health Care Professionals.** Details are found in the current edition of the Guidelines and Standards. Please mark profile below with a horizontal line or an "X" to show appropriate level for each category. In some categories, final level may depend upon driving test. Please check the box below to indicate that a driving test should be taken.

Profile Level	A Diabetes & Metabolic Condition	B Cardio-Vascular & High Blood Pressure	C Pulmonary ☐ Inhaler Only ☐ Inhaler & Meds	D Neurologic	E Epilepsy Or Episodic Conditions	F Learning Memory	G Psychiatric Or Emotional Condition	H Alcohol & Other Drugs	J Musculo-skeletal/ Chronic Debility	K Alertness or Sleep Disorders	L Hearing ☐ (CDL) Balance ☐
1											
2					K MAB C						
3			K	K			K	K	K MAB C	K MAB C	
4	K					K			MAB P	D***	
5						Not Used				S*A**D***	K
6		S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	Not Used	Not Used
7	S*A**D***										
8											

If it is not possible to complete all categories, please check one of the following:

☐ **Non-standard review time frame**_____
☐ Profile categories not marked are relevant and should be completed by another health care professional
☐ There are special considerations I would like to discuss with a representative of the Department or the Medical Advisory Board.
☐ I have not examined this patient recently or completely enough to have a valid judgment.
☐ **I recommend this driver complete a driving skills test in an appropriate vehicle.**

Recommended Restrictions:
☐ Speed* ☐ Daylight only***
☐ Area** ☐ None
☐ Accompanied by licensed driver
K = for Division use only P= Private
MAB = Medical Advisory Board C= Commercial

Date (current within 6 mos.) **Printed Name of Health Care Professional and Degree** **Signature** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

Date (current within 6 mos.) **Printed Name of Health Care Professional and Degree** **Signature** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

(FOR OVERVIEW SEE REVERSE SIDE)